NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

ALRIC WALTER, Plaintiff - Appellant, v. UNITED BENEFIT LIFE INSURANCE COMPANY; and CENTRAL RESERVE LIFE INSURANCE COMPANY, Defendants - Appellees.	No. 04-15789 D.C. No. CV-02-00161-SMM MEMORANDUM*

Appeal from the United States District Court
for the District of Arizona
Stephen M. McNamee, Chief District Judge, Presiding

Argued and Submitted February 14, 2006
San Francisco, California

Before: SILVERMAN, GRABER, and CLIFTON, Circuit Judges.

Plaintiff appeals the district court's denial of plaintiff's motion to remand and grant of summary judgment in favor of the defendants. We affirm in part and reverse in part.

---

* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by 9th Cir. R. 36-3.

Plaintiff argues that the defendants failed to demonstrate the requisite amount-in-controversy such that the district court could properly exercise diversity jurisdiction. We disagree. Because the defendants fulfilled their burden of showing by a preponderance of the evidence that the amount-in-controversy "more likely than not" exceeded $75,000, the district court did not err in denying plaintiff's motion to remand to state court. *See Sanchez v. Monumental Life Insurance Co.*, 102 F.3d 398, 404 (9th Cir. 1996).

Plaintiff appeals the district court's grant of the defendants' motion to strike the revised OME rider. Without any evidence showing either that plaintiff contracted and paid for the new rider or that the two OME rider options could not have remained in effect simultaneously, we affirm the district court's decision to strike the revised rider.

Plaintiff also appeals the district court's grant of summary judgment on the breach of contract claim, contending that the defendants erroneously processed, delayed, or denied payment of multiple medical claims. When interpreting the plain language and purpose of plaintiff's health insurance policy, we conclude there exists a genuine issue of material fact as to whether the defendants breached the insurance policy such that they remain liable for contract damages. *See State*

Farm Mutual Automobile Insurance Co. v. Wilson, 782 P.2d 727, 733-34 (Ariz. 1989).

Specifically, the OME rider is ambiguous as to what it covers. Under the section entitled "Benefits," the rider begins by describing coverage in broad and general terms: "If an Insured Person requires treatment by a Physician for a covered sickness or injury at a Physician Office, Clinic, or Hospital Emergency Room this Rider will provide benefits for each Insured Person." The rider does not define "treatment" or "covered sickness or injury" such that a layperson would necessarily understand that the benefits were limited to only certain treatments. *Thompson v. Gov't Employees Insurance Co.*, 592 P.2d 1284, 1288 (Ariz. Ct. App. 1979) (noting Arizona insurance policies must be "viewed from the standpoint of the average layman who is untrained in the law or the field of insurance"). Defendants take the position that coverage is limited to only those items that are subsequently listed under the heading "Miscellaneous Covered Services and Supplies," and that was the premise of the summary judgment. But the rider does not say that in so many words. Instead, the rider appears to define that term more broadly, without reference to the list: "Miscellaneous Covered Services and Supplies are charges incurred at the Physician's Office, Clinic, Hospital Emergency Room and/or charges incurred by a Diagnostic and Reference Center

on an Outpatient basis." That phrasing does not make it clear that benefits under the policy are limited to the listed items. The itemized list could, for example, represent a group of services that are included even if the rider might otherwise not cover them.

Similarly, the rider fails to define "clinic" such that it is unambiguous, from the "standpoint of the average layman," whether various outpatient locations fall within its scope. *See id.* The possible classification of the Scottsdale Healthcare Shea Outpatient Facility/Piper Surgical Center as a "clinic" is an example of one such ambiguity.

The rider is also unclear as to whether it or the base plan applies (and thus what deductible amount applies) in the event that a procedure is otherwise covered by both documents. While the defendants argue that the base plan applies in these circumstances, plaintiff argues that the rider would cover any such procedure. Significantly, both parties point to the same language to support their respective, notably opposite, positions: "This rider is issued and made a part of the Certificate to which it is attached. WE AGREE TO PAY the Covered Expenses provided by this Rider subject to the provisions of the Group Policy which are not inconsistent with the provision of this Rider." Given the multiple subclauses, double negative,

and undefined reference to "provisions," we conclude that the statement is sufficiently ambiguous such that different interpretations are viable.

Since policy ambiguities must be construed in favor of the insured, we conclude that there is a genuine question whether the following claims were erroneously denied or incorrectly processed under the base plan: (1) Dr. Turkletaub's bill and related facility charges for plaintiff's August 9 skin cancer surgery; (2) Dr. Halliday's pathology fees; and (3) Dr. Koldys' charge for plaintiff's April 25 biopsy. *See State Farm Mutual Automobile Insurance Co.*, 782 P.2d at 733-34.

The defendants concede that they paid the remaining nine claims belatedly, attributing the delay to what they characterize as an innocent computer error. They provide no explanation, however, as to how or why a computer error, innocent or not, constitutes a valid defense to a breach of contract claim. Defendants argue that plaintiff suffered no injury as a result of the late payments, but it does not appear that the district court based the summary judgment on that ground, and we decline to address that issue in the first instance. Accordingly, we reverse the district court's grant of summary judgment for the defendants on the breach of contract claim.

Finally, plaintiff argues that the defendants acted in bad faith. To bring a successful bad faith claim, the insurance company must have "acted unreasonably and either knew or was conscious of the fact that its conduct was unreasonable." *Zilisch v. State Farm Mutual Automobile Insurance Co.*, 995 P.2d 276, 280 (Ariz. 2000). While the defendants may have erroneously denied or delayed multiple claims, plaintiff has not provided sufficient evidence that a reasonable jury could conclude that any payment errors were caused by the defendants' bad faith. Accordingly, we affirm the district court's grant of summary judgment in favor of the defendants on the bad faith claim.

Each party to bear its own costs.

AFFIRMED in part; REVERSED in part; REMANDED for further proceedings.